

THE LESION OF MYO-CARDITIS.

By JAMES GREY GLOVER, M.D.

THE following case is worthy of record because it presents a good instance of a rare lesion in a very pronounced form, and further because of the association of this lesion with, at one stage, very striking anginous symptoms, and finally with sudden death.

Mr. C—, aged fifty, who was the subject of emphysema and occasional attacks of bronchitis, was seized suddenly, on Sept. 15th, at his office, with symptoms thus described to me by Mr. Samuel Lloyd, of High-street, St. Giles's, who was summoned in the emergency. Mr. C— was suffering "from violent sudden pain in the region of the heart, and alarming syncope. It was impossible to properly examine him. The pain extended down the *left arm*." Under Mr. Lloyd's treatment he recovered so far as to get home in a cab. In my absence from town, he was kindly attended by Dr. Cribb, who describes him as suffering in the following way:—"I found him in bed free from all cardiac or respiratory distress, but complaining of pain across the transverse colon from side to side, saying he thought it was 'wind.' He complained of a feeling of 'depression,' and attributed his sufferings to indigestion from having eaten roast pork. His pulse was regular and quiet, respiration neither difficult nor accelerated, there was no pallor or appearance of syncope; extremities warm. I could detect no abnormal sound over the cardiac region, but any such sound may have been masked by his thick covering of fat. Respiration sounds deficient over both backs, but the percussion was clear. I concluded that he had been subject to asthmatic attacks depending on emphysematous lungs. Whatever the attack at the office might have been, of which I got a very imperfect account, it had clearly subsided when I saw him. I prescribed for him a stomachic alkaline mixture and hot applications to the seat of pain.—16th: Had not slept well, and said the pain came on again in early morning and in the same region—viz., across the diaphragm and especially to the *right side* over the liver. He described himself as much better and wanted to get up; no dyspnoea or cardiac symptoms. Temperature normal. His bowels had not acted, so I ordered him an aperient draught and light diet.—17th: The draught acted well, and he described himself as very much better and free from pain, but excessively weak, wanted to get up, and I believe did so. He still complained of an uneasy feeling across the diaphragm, but more over the liver than the heart, always indicating the right side rather than the left.—18th: Was up when I called and said he was getting all right, appetite returning and tongue cleaning, was in much better spirits and walked round his room showing me his paintings; said he should go to business next day, which I believe he did.—20th: Went to business and declared himself almost as well as usual, but weak from the attack. Had no return of pain or discomfort, nor did he complain of any thoracic trouble whatever. Arranged to call on me and report on 23rd; on that day, I believe, walked one and a half miles to my house. He said he only came to show himself, and thanked me for my attention, but would like to look in again in a week." He had so far improved as to have returned to his office, but on Tuesday, September 26th, not feeling well, and having pain in the chest, he was induced, against his strong inclination to go to his office, to remain at home, have poultices on, and to send for Dr. Cribb. Dr. Cribb, knowing of my return, sent the messenger to me. I saw Mr. C— a little after twelve in his library, and was just beginning to hear from him an account of his illness, when his head fell back in his chair, and his feet forward, and he died in a few minutes. A friend at whose house he called the night before said he looked ill and "altered" and complained of "a pain at the heart," but said he should soon be better.

Post-mortem examination.—The body was found very fat and the muscles well nourished. The cartilages of the ribs were so ossified as to require the use of the saw. There was a good deal of fat about the heart; but no hardening of the coronary arteries. The pericardium contained about an ounce, or less, of fluid. There was an ecchymosis on its inner surface opposite the base of the heart, to the left side in front. There was also a little recent lymph hereabouts. But the marked lesion was on the front of the apex of the heart, affecting, apparently, both the surface and a layer of

the substance of this organ. At this spot there was a well-defined roundish patch, less than the size of a five-shilling-piece. It looked badly damaged and on the road to gangrene or sloughing. In colour it was dirty red, with a little dirty lymph about it. The great vessels proceeding from the heart contained decolourised clots of fibrin. The opposing spot of the pericardium had a corresponding appearance—ecchymosed and with a little dirty lymph on it, but with no adhesion. The valves were unaffected. The lungs were emphysematous and congested, but everywhere free from consolidation. The liver was hard, and its capsule at parts opaque. The kidneys were similarly affected, and had a few small cysts on their surface.

Remarks.—I shall not attempt to trace the course of pathological processes in this painful case, nor assign their exact significance. The fibrinous clots in the large vessels probably had much share in causing death. Possibly some similar clotting may have occurred in the nutrient arteries of the heart and so led to the lesions described above, but the coronaries were free from obvious hardness. Possibly, a patient more willing to rest, from the beginning, might have fared differently. The case is interesting in this further respect as one of the gravest heart lesions, with an absence of physical signs thereof.

Highbury.

A NEW METHOD OF CATARACT EXTRACTION WITHOUT EXCISION OF THE IRIS.

By DR. H. GALEZOWSKI.

THE operation for cataract has always occupied the attention of surgeons, and justly so, and many methods, more or less ingenious, have been devised for the extraction of opaque lenses. One of the best of these methods was incontestably the French operation or method of Daviel by flap extraction, which gave numerous excellent results. Unfortunately, however, it not unfrequently happened that the most severe suppurative inflammation supervened even when the operation had been most skilfully performed, necrosis of the cornea and panophthalmitis destroying the eye. In presence of such facts it came to be asked whether a very large corneal flap was not the cause of the suppuration, and whether it would not be remedied by modifying the form of the incision. It was on this account that the old method by flap extraction was replaced by the method of extraction by peripheric linear incision. Our eminent London colleague Critchett, whose loss is regretted by all, brought forward an operation which bears his name, and which consisted in a peripheric linear incision of the cornea, iridectomy, and extraction of the lens with a large curette. After this came the method of von Graefe, or modified linear extraction, which, as is well known, was very soon tried in every country in the world and accepted as being the best, for it did not give rise to suppurative complications. As far as I am personally concerned, I had adopted this last method, and practised it with various modifications, till the last four months. For a long time I obtained satisfactory results, but occasionally I had to record cases of panophthalmitis in patients in whom there was not the slightest reason to anticipate any complication. I have for the last two years employed the most rigorous antiseptic precautions, but this has made no difference. Last year I had five cases of panophthalmitis in ninety-three operations, the results of which I communicated to the International Congress held in London. Quite lately another Parisian oculist has recorded seven cases of panophthalmitis in 150 operations, and in several other records of statistics similar data are to be found. What conclusion should one draw from this? That iridectomy as well as the linear peripheric operation do not prevent subsequent inflammatory mischief. This conviction seemed all the more plausible to me when, at the beginning of the present year, I saw a panophthalmitis appear in one of my town patients who was in an excellent state of health, and who had undergone the operation of iridectomy two years previously with a view of facilitating the subsequent operation. I extracted his cataract under the most favourable conditions; the operation went off perfectly well, and strict antiseptic precautions were observed. What then was my astonishment when, within the first twenty-four